



Health Benefit Plan Summary - BlueSelect Plus ASO PPO \$3000 (OOPM \$3000) MO

This Benefit Summary provides only highlights of the services covered by Blue Cross and Blue Shield of Kansas City (Blue KC). For Additional details, exclusions and limitations refer to your member certificate available at MyBlueKC.com.

General Plan Information

Plan Type	Preferred Provider Organization (PPO) Members can receive services from any hospital or physician, but receive greater benefits when using in-network providers. Services rendered at Out-of-Network providers are subject to Out-of-Network allowables as stated in your contract, and balance billing may occur.	
Medical Network(s) A complete listing of network hospitals and physicians is available on MyBlueKC.com .	In Area: BlueSelect Plus Out-of-Area: BlueCard PPO/EPO	
Deductible – Embedded You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services.	In-Network Individual: \$3,000 Family: \$6,000	Out-of-Network Individual: \$3,000 Family: \$6,000
Coinsurance The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.	In-Network Member Pays: 0% Plan Pays: 100%	Out-of-Network Member Pays: 20% Plan Pays: 80%
Out-of-Pocket Limits – Embedded The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services. These cost shares apply to the Out-of-Pocket Limit: Coinsurance, Deductibles, Copays Applies to: All Medical and Rx Cost Sharing	In-Network Individual: \$3,000 Family: \$6,000	Out-of-Network Individual: \$6,000 Family: \$12,000
Dependent Limiting Age	26	
Customer Service	PH: 816-395-3558 (local) or 1-888-989-8842 (toll free)	
Plan Benefits - Medical		
<i>When you visit a health care provider's office or clinic...</i>	In-Network	Out-of-Network
Physician Primary Care Physician (PCP) - An internist, family practitioner, general practitioner, or pediatrician.	\$35 Copay/Visit, no Deductible	20% Coinsurance after Deductible
Specialist - Doctors of Medicine (MD), Doctors of Osteopathy (DO), except Primary Care Physicians, and other medical practitioners such as optometrists, psychologists and chiropractors.	\$70 Copay/Visit, no Deductible	20% Coinsurance after Deductible

Other Services & Procedures performed in a provider's office and not included with an office visit	Deductible, then no charge	20% Coinsurance after Deductible
Urgent Care Center	\$70 Copay/Visit, no Deductible	20% Coinsurance after Deductible
Blue KC Virtual Care - Office Visit Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
Blue KC Virtual Care - Behavioral Health Therapy Virtual Care provided by Blue KC virtual care partner(s).	No member cost share	Not applicable
Preventive Screenings & Immunizations (Children & Adults) Blue KC health plans include routine preventive benefits that are consistent with the guidelines developed by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Services must be billed with a primary diagnosis of preventive to be covered at 100%. Refer to your member certificate for additional details.	No member cost share	20% Coinsurance after Deductible
Labs Performed in a Provider's Office/Independent Lab/Urgent Care Facility	No member cost share	20% Coinsurance after Deductible
Allergy		
Allergy Testing	Deductible, then no charge	20% Coinsurance after Deductible
Allergy Treatment	Deductible, then no charge	20% Coinsurance after Deductible
<i>When you need radiology services...</i>	In-Network	Out-of-Network
X-Ray	Deductible, then no charge	20% Coinsurance after Deductible
Other Radiology Procedures (MRI, CT/PET Scans, MRA) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
<i>When you have out-patient surgery...</i>	In-Network	Out-of-Network
Outpatient Surgery Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	20% Coinsurance after Deductible
<i>If you need immediate medical attention...</i>	In-Network	Out-of-Network
Urgent Care Center Office Visit	\$70 Copay/Visit, no Deductible	20% Coinsurance after Deductible
Emergency Services Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	Deductible, then no charge	In-Network Deductible, then no charge
Ground Ambulance Out-of-Network benefits are subject to the plan's allowable charge. Out-of-Network providers may bill the member for the remaining balance. See Certificate for details.	Deductible, then no charge	In-Network Deductible, then no charge
Air Ambulance	Deductible, then no charge	In-Network Deductible, then no charge
<i>If you have a hospital stay...</i>	In-Network	Out-of-Network
Hospital Facility Fees Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Physician (Surgeon) Services	Deductible, then no charge	20% Coinsurance after Deductible

<i>If you need help recovering or have other special health needs...</i>	In-Network	Out-of-Network
Skilled Nursing Care Prior Authorization Policy Applies Maximum benefit of 30 Day(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Home Health Services Prior Authorization Policy Applies Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Physical Therapy Maximum benefit of 60 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Occupational Therapy Combined with Physical Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Skeletal Manipulation performed in a Chiropractic Office	Deductible, then no charge	20% Coinsurance after Deductible
Speech Therapy Maximum benefit of 20 Visit(s)/Calendar Year for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Hearing Therapy Combined with Speech Therapy Limits	Deductible, then no charge	20% Coinsurance after Deductible
Durable Medical Equipment Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Hospice Services Prior Authorization Policy Applies Maximum benefit of 14 Day(s)/Lifetime for In-Network and Out-of-Network	Deductible, then no charge	20% Coinsurance after Deductible
Home Hospice Services	Deductible, then no charge	20% Coinsurance after Deductible
<i>If you have behavioral health, or substance abuse needs...</i>	In-Network	Out-of-Network
Outpatient Mental Health, Behavioral Health, and Substance Abuse Services Office Visit	\$35 Copay/Visit, no Deductible	20% Coinsurance after Deductible
Therapy	\$35 Copay/Visit, no Deductible	20% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Facility Fees) Prior Authorization Policy Applies	Deductible, then no charge	20% Coinsurance after Deductible
Inpatient Mental Health, Behavioral Health, and Substance Abuse Services (Physician) Includes: Therapy & Other Services, partial hospitalizations	Deductible, then no charge	20% Coinsurance after Deductible
<i>Family Planning & Pregnancy...</i>	In-Network	Out-of-Network
Contraceptive Devices, Implants, and Injections See also pharmacy benefits.	No member cost share	20% Coinsurance after Deductible
Elective Sterilization – Women	No member cost share	20% Coinsurance after Deductible
Elective Sterilization – Men	No member cost share	20% Coinsurance after Deductible

Maternity Dependent daughters are covered for maternity services	Covered	Covered
Infertility and Impotency Diagnosis and Treatment Pharmacy Coverage: Not Covered	Not covered	Not covered
<i>Routine Vision Care...</i>	In-Network	Out-of-Network
Routine Eye Exam Maximum benefit of 1 Exam(s)/Calendar Year for In-Network and Out-of-Network Provided by Vision Service Plan (VSP)	\$20 Copay/Visit, no Deductible	\$20 Copay/Visit, no Deductible Limited to \$45 Benefit Max per Calendar Year.
General Pharmacy Information		
Retail Pharmacy Network(s)	RxPremier	
Prescription Drug List Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	Premium Formulary	
Specialty Pharmacy A Specialty Pharmacy is one that provides specialized care for patients with complex chronic health conditions. Learn more about the drugs covered by your plan, drug category/tier, prior authorization and step therapy by reviewing your prescription drug list at MyBlueKC.com	OptumRx Specialty Services PH: 1-855-427-4682	
High-Cost Drug Discount Program	The program can help you secure financial assistance which may substantially reduce or completely cover your out-of-pocket costs for your qualifying medication(s). Only your true-out-of-pocket costs will be applied to your deductible and/or out-of-pocket totals.	
Outpatient Prescription Drug Out-of-Pocket Limits The Out-of-Pocket Limit is the most you could pay during the Calendar Year for your share of the cost of covered services.	In-Network	Out-of-Network
	Combined with Medical Out-of-Pocket Limits	Combined with Medical Out-of-Pocket Limits
Plan Benefits – Pharmacy		
<i>When you use a retail pharmacy...</i>	In-Network	Out-of-Network
Retail Pharmacy (Short-term supply: Up to 34 Days)		
Drug Tier 1: Generic	RxPremier: \$15 Copay/Fill Contraceptives – No member cost share	\$15 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	RxPremier: \$70 Copay/Fill	\$70 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	RxPremier: \$110 Copay/Fill	\$110 Copay/Fill, then 50% Coinsurance
<i>When you use a specialty pharmacy...</i>	In-Network	Out-of-Network
Specialty Pharmacy (Day supply: Up to 34 Days)		
Specialty Drug Tier 1: Generic Specialty	\$15 Copay/Fill	\$15 Copay/Fill, then 50% Coinsurance
Specialty Drug Tier 2: Preferred Specialty	\$110 Copay/Fill	\$110 Copay/Fill, then 50% Coinsurance
Specialty Drug Tier 3: Non-Preferred Specialty	\$200 Copay/Fill	\$200 Copay/Fill, then 50% Coinsurance
<i>When you use a mail order pharmacy...</i>	In-Network	Out-of-Network
Mail Order Pharmacy (Mail Order supply: Between 35-102 Days)		

Drug Tier 1: Generic	\$37.50 Copay/Fill Contraceptives – No member cost share	\$37.50 Copay/Fill, then 50% Coinsurance
Drug Tier 2: Preferred	\$175 Copay/Fill	\$175 Copay/Fill, then 50% Coinsurance
Drug Tier 3: Non-Preferred	\$275 Copay/Fill	\$275 Copay/Fill, then 50% Coinsurance

Discrimination is Against the Law

Blue Cross and Blue Shield of Kansas City (Blue KC) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話1-844-395-7126。

Blue KC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

